Applicant Name (Last)

Nevada wil

with the cost of prescription medicines if you qualify: provide assistance

- Age 18 through 61 with disability
- For current income limits, Nevada resident continuously for at least the last 12 months
- http://dhhs.nv.gov/DisabilityRx.htm **1-866-303-6323** or go to:

Tear along this perforation. Fold up completed application form, moisten glue strip and apply to edge indicated.

Not Medicare Eligible:

No monthly premium

No deductible

The Benefits to You:

Complete this form, sign below, and return it to the address listed on the back. **Applicant Contact Information** Applicant Information (Please Print) Residence Last Name. First Name. Middle Initial Number, Street, Apt. or Space Number Address Date of Birth Social Security Number City, State, Zip Code IF MEDICARE ELIGIBLE (REQUIRED INFORMATION) Mailing Number, Street, Apt., Space Number or P.O. Box Address Medicare Effective Date Citv. State. Zip Code Medicare Prescription Drug Plan Name (no abbreviations please) Telephone Monthly Part D Premium (if any) Male ☐ Female ☐ E-Mail Address Have you lived in Nevada continuously for 12 months Spouse Information (Please Print) Yes \square No 🗆 prior to the date of this application? Are you applying for Disability Rx also? Yes ☐ No ☐ What is your disability? Even if not applying, please provide the following information. If you receive any help based on your disability, Last Name, First Name, Middle Initial provide the agency name. **List All Current Monthly Income Received** Date of Birth Social Security Number Type of Income **Applicant** IF MEDICARE ELIGIBLE (REQUIRED INFORMATION IF APPLYING) Medicare Number with LETTER Medicare Effective Date Medicare Prescription Drug Plan Name (no abbreviations please) Total monthly income from all sources (Income includes Social Security, SSI, Pensions/IRAs, Interest Monthly Part D Premium (if any) Male ☐ Female ☐ and Dividends, Wages, Real Estate Rental, and Others.) Capital Gains (Loss) on last tax return Have you lived in Nevada continuously for 12 months Business Income (Loss) on last tax return Yes 🗌 No 🗆 prior to the date of this application? **Confidentiality Statement** If applying, what is your disability? Information provided on this application is confidential. disclose or use any personal or confidential information contained on this application except for purposes connected to the administration of this program. Unauthorized If you receive any help based on your disability, osures are a violation of the Health Insurance Portability and Accountability Act

(HIPAA) and may result in civil penalties. Please Note: If someone other than the appli-Power of Attorney or Letters of Guardianship must cant or spouse signs, a copy (non-returnable) of a

For Statistical Purposes Only

Check one box for applicant and one box for spouse (if any)

☐ ☐ American Indian/Alaskan Native

By signing this application, I agree to the following:

his information is voluntary and will be kept separate and

confidential

☐ ☐ Hispanic

Asian/Pacific Islander ☐ African American

If it is determined that I received Disability Rx To immediately provide to the Department of disability, and Medicaid, SSI or Medicare change of address, name, household income, benefits that I was not eligible to receive, I will marital status, telephone number, status of Health and Human Services written notice of a

That as a condition of, and for purposes of refund to the Department of Health and Human Services all amounts paid on my behalf

provide the agency name.

declare that the information in this application authorize the Department of Health and Human valid for a period of 14 months from the date of Services to verify my eligibility, including my disability upon request. This authorization is income, and I will provide documentation of my determining eligibility for this program, I

best of my knowledge and ability. or the Disability Rx program is accurate to the

Print Name Applicant Signature Date

Spouse Signature

⊃rint Name

attached application and drop in any

you think you qualify, complete the

gap (or "donut hole")

Medicare Eligible:

Help with monthly premiums to

Medicare Prescription Drug Plan

Help with prescription costs if you

are subject to the Part D coverage

Coverage limit of \$5,100 Co-payments of \$10 or \$25

mail box. No postage necessary

http://dhhs.nv.gov/DisabilityRx.htm

-866-303-6323

For more information: